

best placed to have these conversations. Hospice nurses reported numerous potential barriers to extending their role including: impact on peer relationships and relationships with doctors; anxiety about having DNACPR discussions with some evidence of censoring of conversations and selection of which ones they would engage with; anxiety about the responsibility for such decisions if the patient changed place of care. Although participants did not perceive stable or prolonged illness trajectories as a barrier for discussing DNACPR, they did consider a patient's uncertainty about the prognosis to be a barrier.

**Conclusion** Hospice nurses exhibited cognitive dissonance; they had discord between knowing what good practice was and completing it in action. They appeared to value 'niceness' over honesty and their censoring of conversations resonates with communication awareness theories.

P-110 ABSTRACT WITHDRAWN

P-111 WITHDRAWAL OF NON INVASIVE VENTILATION IN PATIENTS WITH RESPIRATORY DISEASE IN A HOSPITAL SETTING

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**Background** Withdrawal of non invasive ventilation (NIV) in patients with motor neurone disease has been well documented. However, little is published about the process in patients using it acutely for respiratory failure associated with a primary respiratory disease.

**Aim** This audit provides a retrospective collation of cases in which NIV was withdrawn in patients commenced on the treatment acutely in the hospital setting.

**Methods** Cases were identified using the search function of the electronic palliative care notes between April 2016 and April 2017. Patients identified as undergoing withdrawal of NIV or discussion about NIV withdrawal had hospital notes obtained for analysis. Nine patients fitted the criteria. Six underwent a planned withdrawal of treatment. Hospital notes and drug charts were reviewed to provide data on the withdrawal process.

**Results** Average length of hospital stay was 8.5 days. Palliative care referrals were made on average 2.57 days prior to withdrawal with 57% of cases being referred the same day. Decision to withdraw was documented on the same day withdrawal took place in 100%. The decision was discussed with 50% of patients and 83% of families by a range of healthcare professionals. Ventilator weaning took place in 50%. Medication administration demonstrated a range of practice. Pre-medication was documented in 33%, post withdrawal bolus doses were required in 50%. Administration route was a mix of IV bolus, SC bolus (dose range of 1–7.5 mg of midazolam and 3–7.5 mg of morphine) and syringe driver (average starting dose 13.5 mg midazolam and 12.5 mg morphine). 71% of patients died within 24 hours of ventilation withdrawal. No patient survived >48 hours. All died in hospital.

**Conclusion** Decision making and treatment withdrawal in this patient group is rapid. Practice of withdrawal and

pharmacological intervention is varied. This highlights the need to develop guidance for the process of NIV withdrawal in the hospital setting and the need for clear standards of documentation when undertaking withdrawal decisions discussions.

P-112 INDIVIDUALISED CARE PLANNING FOR DYING PATIENTS – AUDITS TO IMPROVE PRACTICE

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**Background** Recognition of dying is an integral part of best practice in end of life care. The Dying Phase (DP) is included in the Outcome Assessment and Complexity Collaborative (OACC) suite of measures. Individualised care plans for dying patients have been a key initiative since the demise of the Liverpool Care Pathway. At our hospice Phase of Illness has been captured on our electronic patient record (Crosscare) for two years and a new care plan for the dying window introduced in November 2016. The care plan was created to be used across clinical settings with a printable option for patients cared for in the community.

**Aim** To review patient records in a 15-bedded hospice inpatient unit and evaluate if DP was recognised in a timely manner and appropriate care plan commenced.

**Method** All patients who died or were identified as dying in the two months following the initiation of the new care plan were included. Notes were retrospectively reviewed including dates DP was recorded and care plan created. An Excel toolkit was used to analyse the quantitative data. A separate quality review of care plans was conducted by a senior nurse.

**Results** 37 patients were included in the audit. 32 had DP completed, of these two did not have individualised care plans completed as they died quickly. Only 29 had OACC phase updated. Mean length of time in DP was three days (range <1 day to 8 days). Quality of care planning was generally good and used as feedback for training.

**Conclusion** Incorporating Phase of Illness and individualised care plans for the dying person is important in the hospice setting with electronic records. This audit informed amendments to improve practice including retrospective entry of care plan if patient dies quickly and embedding Phase of Illness update into the care plan window.

P-113 BIOMARKERS OF DYING IN CANCER PATIENTS; AN EXPLORATION OF THE BIOLOGY OF DYING

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**Background** The Neuberger review made a number of recommendations to improve end of life care, including research into the biology of dying. An important aspect of the biology of dying is the identification of biomarkers as indices of disease processes. Biomarkers have the potential to inform the current, limited understanding of the dying process and assist